

**ALBERTA AIDS TO DAILY LIVING (AADL)
WHEELCHAIR REPLACEMENT REQUEST**



Client Name (Last) (First)		Personal Health Number (PHN)	
Authorizer Number:		Authorization Number:	
Residence: <input type="checkbox"/> Home <input type="checkbox"/> Lodge <input type="checkbox"/> Group Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other:			
Diagnosis:			
WHEELCHAIR CURRENTLY IN USE			
Serial Number:		Make:	
Model:		How long has client had this wheelchair:	
CURRENT PROBLEM			
Who is complaining about the chair:		What is problem?	
Is this a problem for the client: <input type="checkbox"/> Yes <input type="checkbox"/> No How:			
How many hours a day does client use current w/c:		Environment changed:	
PRIMARY ANTICIPATED OUTCOME (if request is approved)			
State:			
WHAT IS WRONG WITH CURRENT WHEELCHAIR			
DOESN'T FIT CLIENT			
<input type="checkbox"/> Width <input type="checkbox"/> Depth <input type="checkbox"/> Seat to floor height		Can chair be grown/shrunk rather than replaced?	
AADL estimate to grow (AADL use this space \$_____)		Vendor says: <input type="checkbox"/> Yes <input type="checkbox"/> No	
DOESN'T SUPPORT CLIENT'S WEIGHT			
Client changed weight: <input type="checkbox"/> Yes		Current weight:	Current weight stable for 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs/disease affecting weight: <input type="checkbox"/> Yes <input type="checkbox"/> No		Short-term or long-term use of drugs:	
CHAIR IN POOR CONDITION			
What factors led to this poor condition:			
Checked by vendor: <input type="checkbox"/> Yes (work order attached)		Written off by AADL: <input type="checkbox"/> Yes <input type="checkbox"/> No	
PARTS CHANGE WITHIN 6 MONTHS OF RECEIVING CHAIR			
What:		Why:	
CHAIR TOO HEAVY FOR CLIENT TO PROPEL			
Weight of current wheelchair:		Weight of requested wheelchair:	
Requested chair:			
WHAT STEPS HAVE BEEN TAKEN TO MAKE THE CURRENT CHAIR WORK			
Client wheeling ability examined: <input type="checkbox"/> Yes <input type="checkbox"/> No		Assist caregiver in handling chair properly: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home environment modifications needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is client willing to do modifications: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tried quick release axles: <input type="checkbox"/> Yes <input type="checkbox"/> No		Chair configuration adjusted by w/c dealer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
USE OF CUSHION			
Does client use a cushion: <input type="checkbox"/> Yes <input type="checkbox"/> No		When did client receive the cushion:	
Make/Model:	Size:	Thickness:	Different cushion trialed: <input type="checkbox"/> Yes <input type="checkbox"/> No

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CHANGE IN CLIENT

Document change in medical condition:

Document change in functional independence:

CLIENT NEEDS TILT

CLIENT NEEDS RECLINE

Why:

Why:

Pediatric – Tilt request is attached: Yes No

Adult – Aware of financial implications: Yes No

CURRENT USAGE

Does the client self propel: Yes No

Using arms: Yes No

Using feet: Yes No

Both: Yes No

Is client independent in current wheelchair: Yes No

Does the client go outside in wheelchair: Yes No

How often _____ How far _____

Alone, or Accompanied

WHEELCHAIR REQUESTED

Is there a change in configuration of trial chair: Yes No If yes, what:

Was it trialled in home: Yes No **If no, you must trial before sending in the request.**

Where trialled:

How long was trial:

OUTCOME OF TRIAL

Increased independence

Increased comfort

Less pain

Improved posture

Increased safety

Decreased injury

Decreased potential for skin breakdown

Increased distance for wheeling: How far _____

Sitting tolerance (able to sit longer): How long _____

Easier for caregiver: How _____

Easier transportation: Why _____

Other _____

Spec. sheet attached: Yes No

How will they **transport** this chair:

CAREGIVER ISSUES

Caregiver has been instructed in handling current wheelchair

Caregiver has been shown how to release quick release axle

Caregiver has health issues: What _____

Client is pushed in chair: By whom _____ Age _____ How often _____

Caregiver Impairments _____

SEATING

Does client need a referral to seating clinic: Yes No

Has client been seen in seating clinic: Yes No

Does current wheelchair have **special seating** attached: Yes No If so, what: Back Laterals Headrest

If yes, have you discussed this request with a Seating Clinic team member: Yes No

IF NO, DO SO BEFORE GOING FURTHER WITH THIS REQUEST

Will seating need to be:

At what cost:

Does this request require a change in seating: Yes No

Changed out: Yes No

Modified: Yes No

AADL use only – Seating request approved: Yes No

See attached for more information (optional)